MISSOURI DEPARTMENT OF LABOR AND INDUSTRIAL RELATIONS
DIVISION OF WORKERS' COMPENSATION
3315 West Truman Blvd., P.O. Box 58
Jefferson City, MO 65102-0058

MOTION TO WITHDRAW

INJURY NUMBER

__ __ - __ __ __ __ __ __

_____,
Employee

vs.

_____,
Employer

and

_____,
Insurer

_____,
Third Party Administrator

Date of Accident/
Occupational Disease: _____

MOTION TO WITHDRAW

On behalf of the ☐ Employee ☐ Employer / Insurer / Third Party Administrator *(Please circle the appropriate party.)*
COMES NOW, the undersigned attorney and requests Leave to Withdraw as attorney for the _____
(specify the name of the party). In support of the motion, the undersigned states as follows: _____

_____

Should a hearing be set on this motion: ☐ Yes ☐ No This case is set on the following docket:
_____ Pre-hearing _____ Mediation _____ Hearing.
The docket date is _____.

Respectfully submitted,
Signature _____
Attorney Name _____
Law Firm _____
Address _____
Phone No. _____
Fax No. _____
Bar No. _____
E-mail Address _____

Leave Granted: _____
Administrative Law Judge

Date: _____

CERTIFICATE OF SERVICE

I certify that a copy of this Motion to Withdraw was mailed or hand delivered to all parties of record, or if represented by an attorney, to their attorneys of record this
_____ day of _____ , 20____.

Attorney's Signature _____ Bar No. _____
Attorney's Name *(Printed)* _____ Date _____
Address *(if different than above)* _____

DIVISION USE ONLY

DATE STAMP